

New Options for Health Care Policy and Health Status Insurance: Citizens as Customers

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Health education and health literacy programs have implications on health care policy and health care status insurance. There are many benefits of a transition from disease management to a health care system, which includes priorities in prediction, prevention, and health education. Health care and disease management could best be implemented by multiple-tier, market-oriented models of universal coverage allowing for competition among health status insurers and educational, pharmaceutical, nursing, and other health service providers. Promotion of health literacy will allow citizens to become educated customers and consumers of health care services. Internationally, health literacy might narrow the gap between economically richer and poorer countries.

Key words: *disease management; health education; health policy; insurance, health; public health; risk factors; risk management; universal coverage*

Predictive and preventive medicine, risk factor medicine, health information, biotechnology, and pharmacogenetics are making great progress, allowing for better and individualized health status protection, health enhancement, and disease management. But these developments have not yet been translated adequately into governmental and institutional health care policy. Overregulated disease management systems appear outdated, while health care technologies and capabilities enjoy innovation and progress. People complain that medical care and medical insurance are too costly, too inefficient, unjust, and inadequate, but they lack individual health care competence and risk awareness (1-3). Health-literate citizens could make educated care choices, whereas health-illiterate cannot. Health-literate people might make better patients; educated consumers are in general better customers.

Transition from Disease Management to Health Care

It has rightly been observed that traditional physician-patient relationships have been replaced by corporate medical practice, market economy, and consumer culture (4). However, this culture is not the culture of educated customers and consumers of health care services; it is a repair-mentality culture created by disease treatment systems paying for repair in commodified diagnosis-related package deals. Additionally, in countries lacking universal coverage, groups of different risk profile are put into different

disease care packages and insurance boxes, whereas a high percentage of people are not covered at all, as is the case in the United States (2,3). What is needed is a transition from the existing disease management systems to the models of stakeholders who truly protect, improve, and care for health, making citizens stakeholders in risk factor reduction and health protection.

Given the central role of existing corporate medical service and disease management, administered by institutions and financed by insurance companies via commodified reimbursement packages, the prime moral agents to change existing disease management systems into true health care models are governmental health care policy and insurers. They are setting the framework for educated customers and qualified providers of health care, health education, and disease management services. Short of a civil revolution or patient rebellion, striking medical personnel, and ever increasing and ever more unjust insurance schemes, a blunt and structural reform seems to be the only fair and practical solution. In corporate medicine providing sickness-treatment commodities (4), the individual physician and individual patient or counselee are not powerful enough to change the system, only the players in health policy and health status insurance are.

Caring for health is more than managing disease. The care for health is primarily personal issue and interest, an issue of self-determination and individual quality-of-life decision making, only secondary an ob-

ligation of the family, community, or government. Individual citizens are prime beneficiaries, customers, and consumers of health care services. Assisting people in caring for their health and reducing health risk and health care risk could and should be a most successful business and a good investment. Providing service for one of the most fundamental human needs also holds social, cultural, and ethical merits. Modern medicine has improved success rates in intervention, prediction, and prevention and could provide for extended opportunities for beneficiaries and those in the business of health care services.

Towards New Concepts of Health and Disease

As scientific knowledge changes rapidly, transfer of knowledge and a revised understanding of health and disease have to follow. Traditional concepts of health have become obsolete in risk factor medicine, and so have the health policies based on outdated models of health. Health cannot simply be understood anymore as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity" (3,5), but rather as a process of challenge and response, a process of balancing, which needs understanding, protection, and management by the individual person. Health is not just a status. It is more a balanced result of health-literate and risk-competent care of one's own physical, emotional, and social well-being. It is achieved by competent understanding, modification, and enhancement of individual genetic, social, and environmental properties and risk factors, with the support of health care professionals and through equal access to health care services, including information and preventive medicine.

The World Health Organization (WHO) definition of health has outlived its usefulness and needs to be replaced by a new concept of health and health care (3). The new situation requires us to reevaluate and reprioritize traditional principles of care, confidentiality, beneficence, informed consent, and harm. The WHO definition has never reflected or included the immense progress made in health status and life expectancy by millions of people via better hygiene, water, nutrition, clothing, and above all – education. It is unquestionable that non-medical improvements in everyday life have increased the quality of health and life and that the percentage of medical expenditures in gross domestic product does not correlate with life expectancy and probably not with quality of life either (6). Many studies have shown that disease management expenditures, ie, expenditures in the health care sector, do not correspond with life expectancy, and quite often there is an inverse relationship between health care costs and life expectancy (2,3,5,6). But the correlation between improvements in socio-economic and educational conditions and health status is well proven, as is influence of tobacco, alcohol, human immunodeficiency virus, and inadequate nutrition (2,3). Therefore, we will have to focus on modified bioethics principles, such as duty to accept information, the right to be told and to

know, health education, health literacy, health care competence, informed request, informed contract, and data availability.

Empowering the Individual to Care for Health

As health is a basic human good, transition periods such as ours fare best when traditional medical and moral principles are reassessed in the light of new and expanded opportunities, rather than invented anew. The individual's self-interest, health knowledge, health responsibility, and the community's solidarity and support have always been prime ethical principles in the care for health (5). Both principles, health responsibility and solidarity in managing health risks, are still good for building a firm foundation for a future system of health care and health insurance. Health care policy, health care insurance, and health care providers need to discover and empower the citizen as a customer and consumer of health care services (4,7). Better efficiency and utility of health care could depend on giving the educated citizen a more active role in caring for her or his health and on promotion of health literacy and health competence among citizens.

The right information is a prerequisite for making the right choices. Information on health management, which could be available, is rarely provided by existing disease management systems. In richer and educated countries, however, health food stores, drug stores, and the media furnish information on healthy lifestyle and nutrition, and so do an ever growing number of sites on the Internet (8-10). Since disease management system in rich countries takes care of the negative outcomes of taking health risks, there is little or no incentive built into the system for the individual citizen to avoid health risks and exercise individual rights to good health care. At the same time, poorer countries, having no fully developed disease management and insurance systems and no equal access to limited services, also rarely provide information and education on health management, healthy lifestyles, and nutrition. Thus, both systems deprive their citizens of basic human and civil rights to education, knowledge how to care for their health, pursuit of happiness, good and long life, and means for self-determination, relative independence, and autonomy.

The ethical principle of solidarity in the Bismarckian model was adequate when, due to the lack of medical knowledge, medical intervention was limited in scope and expense (3). However, in times when we can predict how and when the risk for individual health will occur, it is not adequate any more (1,3,11). Therefore, the principle of solidarity needs to be complemented and balanced with principles of health literacy, health care competence, and health responsibility. Subsequently, provider systems and insurance systems have to be restructured to implement and support a new triad of principles in health care: education, solidarity, and responsibility (11).

Empowering individuals to make prudent health care decision requires education and advice. Such education can be given within the established public general educational system, as well as through spe-

cial and free health care classes addressing special health care issues. One of the few insurance companies in Germany, Barmer Ersatzkasse, offers physical exercise classes such as yoga to everyone, and for a smaller fee to those ensured by other companies. Many individuals already seek information and advice outside the established disease-management system, in alternative medical literature and traditions or on the Internet, including prestigious intuitions, such as Harvard and Johns Hopkins University (9). Information providers, of course, are of different quality: some offer low-quality or even misleading information and exploit the opportunities of the Internet for financial gain, whereas others provide high-quality information, advice, and opportunities for interactive communication. The latter should set the standard.

Certification of e-health websites is under consideration (12,13). In the United States, over 66% of adults have access to the Internet and more and more citizens seek information and advice on health care or disease management on the web. They pay the access to e-health sites, such as webmd.com, or to virtual visits to individual physicians or physician offices, such as those at medhelp.org or mayoclinic.com. Some websites are free of charge, other (e.g., *www.aska-doctor.com*) charge around US\$20 per question answered by three e-mails from different physicians. Many insurance companies, such as Cigna Corp, First Health Group, or ConnectiCare, will soon follow the example of Blue Shield of California insurance company, which pays for online medical consultations of its users (14). Slowly but constantly, the Internet establishes a second reality for health care information, education, and management parallel to and outside of the disease-management system supported by the government and paid for by insurance models fitting the governmental model. Physicians see more and more patients who are better informed than they are; these patients visit websites for professionals or interactive health care groups (2,11). Governmental and institutional health care policy has not yet fully recognized the power of the Internet in furthering information, education, autonomy, and responsibility into various areas of life, let alone in caring for health.

The prerequisite to make health care and health insurance more efficient is to reconfirm a prudent mix of solidarity and responsibility, dormant in our cultures and not implemented in the foundation of existing health care and health status insurance models.

Structuring Just and Efficient Health Care Systems

Disease-management systems based on the principle of solidarity alone face political, ethical, and medical questions of rationing services, promoting passive attitudes towards caring for health, and not supporting health literacy or providing preventive health care services. Health care systems equally based on solidarity and responsibility support an active role of the individual in the care for health. They allocate specific prime responsibilities and obligations between the individual and the community, thus allowing for basic health care services in educa-

tion and acute and chronic intervention as well as for individualized health care risk management based on the individual's values, wishes, and risk profile (3,11).

As structured markets are more efficient than governmental tutelage or management, so should the details of health care services and intervention management be left to the providers of services and finances. A government supporting needy citizens by paying basic health status insurance premiums provides more opportunities, in particular to the sick, the frail, and the needy, than do models of so-called socialized medicine, such as those in Canada and Great Britain, which unjustly ration access to disease management and life-saving treatment by waiting lists or by making certain services completely unavailable (8,11,14).

Consequently, two-tier or multiple-tier health care and insurance markets are the best way to translate principles of solidarity and responsibility into true, just, and efficient health care system. Although making basic decisions between the structure and the content of two or more health care packages is a governmental responsibility, there should be enough flexibility left for individual choice and market competition (Table 1).

Table 1. Model packages of just and efficient health insurance

Basic services – mandatory:*
health education
individual health risk
basic acute care
basic chronic care
full palliative care
Supplementary services – voluntary:†
lifestyle health risk
occupational health risk
individual basic + services

*Premium independent of risk.

†Premium depending on risk assessment.

Basic health care and health insurance need to include basic services in health education, acute interventions, and chronic care, as well as full services in pain management and management of individuals with inherited genetic disorders or individual health risk features. Financing of basic health care must be based exclusively and solely on the principle of full solidarity. Education is a tool to support and enable individuals to understand information and make competent choices. As urgent and life-saving interventions may be needed by everyone anytime, it is only just that these basic risks are taken care of and financed by the community.

Each of us has different genetic advantages and disadvantages, abilities and disabilities. These differences can and should be bridged by giving better opportunities to those faced with a more complex and complicated challenges in caring for their health than to others. Thus, individual abilities and disabilities should be taken into account when structuring individual basic health care packages.

Premiums for basic health care services need not be based on required services or selection of individual risk factors, but should be defined on the basis of solidarity alone. Such a system might use a certain

percentage of income of the employed, whereas the community could pay for those who have no income, treating it either as a gift, a loan, or a refundable tax credit.

Supplementary health services will be based on individual concepts of risk management, health protection, and anti-aging lifestyle risk. They have to be bought on a competitive market and based on the amount and profile of risk insurance required. As individual risk tolerance and concepts of quality of life and health care differ, so will the premiums for supplementary health care services and insurance in competitive market. It would be an issue of fairness and good business that premiums for supplementary insurance take individual risk factors into account.

Finally, there will be people who cannot cope with a system based on solidarity and responsibility. They might lack the intellectual capacity or the will-power to act responsibly, take care of themselves, understand risk, or they just might not care. But as pain, illness, suffering, and burden of disease are shared by all humans, we all have to accept the responsibility for our fellow humans. Charity has traditionally taken care of citizens who fell through the main social support systems of society, who were not taken care of by anyone. In those situations, the principle of subsidiarity has played an important role (3,11) in covering holes in existing systems of solidarity and taking care of individual cases that were so special and so specific that it would have been imprudent to structure the whole policy around them. As each and every system has to be simple and just, there will always be individual cases that fall through the grids of law and regulation. Over the centuries, the subsidiarity principle has played an important role in addressing individual needs beyond the legal or financial constraints of routinely administered social services. Thus, the principle of subsidiarity will call for individual, cultural, and political support to charities and special interest groups (3).

Humans are too different to be cared for by simple systems. Systems of care have to be open to individual needs and shortcomings. But systems also have to be consistent in their priorities and what they support and empower. As far as health care is concerned, the principles of solidarity and responsibility together provide a good combination for building and supporting health care systems that recognize the need to act according to solidarity principle in catastrophic and basic risk management, to support individual self-determination, and allow for individual concepts of quality of life and risk. Both principles need to be supplemented by the principle of subsidiarity, handling extreme cases and providing care and compassion beyond the boundaries of basic and supplementary health care and health insurance. Political and social support for the principle of subsidiarity in itself is an insurance policy for a system based on solidarity and responsibility.

While most issues in health care and catastrophic illness can be taken care of by two-tier models, providing market-driven individual-choice flexibility in supplementary packages, other health risk as-

sociated with controversial personal choice or hazardous activities can and should be dealt with separately. Workplace and traffic accident insurance schemes are already in place (2,3). Other special health risk, such as risk associated with sports, smoking, or drinking could be insured in similar ways. Consumption of alcohol and tobacco is already highly taxed, but taxes are not used for the support of basic health care packages and promotion of health literacy, but rather for other areas of government spending. This is unjust and inefficient as governments have a conflict of interest in skimming off taxes from proven or assumed unhealthy behavior and spending it elsewhere but not on the promotion of health literacy and health care.

Also, in pluralistic societies there are many controversial medical interventions, such as abortion or even contraceptives (3). Is it fair to ask those who oppose contraception or abortion to fund the expenses associated with procedures they condone within universal basic packages? Using the principle of subsidiarity or individually selected third-tier insurance would be more adequate tool to cover these expenses.

There will be even harder questions: what about those who do not care about or cannot change their unhealthy behavior, who do not bother to become health literate, or accept information but do not follow advice? Would it be unfair to reduce basic package premiums to those who use recommended free diagnosis-and-consultation services and routine doctor visits within recommended time frames? I do not think so. Would it be unfair to remind those who repeatedly do not make use of free medical checkups and consultation services of possible adverse consequences of such a behavior on their health? Would it be unfair to those who do not follow medical advice based on proven preventive knowledge to either increase their premiums or ask them to pay for that risk out of pocket, not through the agreed-upon insurance package? The answer to the last question, based on the principle of shared responsibility in universal systems financed on the principle of solidarity, would be negative – no, it is not unfair. However, as long as existing systems are rich enough and those numbers are small enough, we might want to circumvent a blatant answer and instead rely on continued education, counseling, and paying from solidarity for unfair free-riders. And would it be unfair to steward more strictly those not capable of making competent decisions based on prudent self-interest, because of lack of intelligence, will-power, or addiction? Here again the answer most adequate and appropriate for a society based on autonomy, solidarity, and subsidiarity would be to encourage and empower self-determination first, but then to revert to more “paternalistic” measures, at least in extreme cases where someone might already be under guardianship, or voluntarily or involuntarily participate in well-intended programs of betterment or treatment of addiction. These are difficult questions to deal with in the transition from an ethically and medically inadequate model of disease management to a just, efficient, and universal system of the individual and social care for health.

Stakeholders in Efficient Health Care and Health Insurance

To provide good health care is not simply a question of more funds or better distribution of scarce resources (17). Before systems can be changed the attitudes of people need to change, or be encouraged to change, in accordance with the change in the system. Needed is a change in attitudes and in moral principles guiding health care (3,18). There are not just those who provide and those who pay. There are the recipients of disease management who have no saying yet and have not been made prime stakeholders in the business of caring for health. There is more at stake in the care for health than hospital beds, surgery rooms, and senior-citizen homes. The competence and the civil right to take care of one's own health as much as possible are also at stake.

There are many stakeholders in enabling the individual to take care of her or his health. Stakeholders are the politicians and regulators, the insurers and payers, the providers, and last but not least, the prime moral subject – the individual citizen. Stakeholders have different obligations and limits to their abilities, but all share in the same enterprise (Table 2).

Maxims for stakeholders of different kind need to be interactive and complement each other, and will depend on each other. Four sets of interactive rules for the four different stakeholder types (politicians and regulators, lay people, health care professionals, insurance professionals) may illustrate the common goal and the need to communicate and to cooperate with each other (Table 2). The framework has to be set

by policy and law, but there must be enough room for the citizen to make educated choices.

Guiding ethical principles for all groups of stakeholders should be: the individual's right to care for her or his health, solidarity in providing opportunity chances and in sharing risks and costs, trust in individual health competence, support of health literacy and education, trust in the forces of a regulated market and in the competitive powers of quality-controlled services and insurance models. Important as systems are, they need to be lived in by people. Changes in attitude are necessary and will have to occur in interaction with transition in systems. Therefore, instead of entertaining details of two-tier or multiple-tier health status care, I submit for discussion maxims, based on ethical principles, to guide stakeholders directly. These four sets of maxims are interactive and can be used in education, training, quality control, and devising regulation and models of insurance.

Efficient health care is more than high quality of medical intervention and expertise, or high percentages of gross national product allocated for disease management or medical treatment for the needy. Health care is about being able to care for one's own health with more or less support from professionals. As far as education and competence in health care matters is concerned, rich as well as poor countries have neglected to enable their citizens to avoid health risk and make health care decisions on their own. Rarely is the promotion of health literacy and health care competence found in any basic package of privately or publicly funded insurance schemes. This ne-

Table 2. Stakeholder maxims in health care

I Eight health care rules for *politicians and regulators*:

1. Base policy on solidarity, responsibility, subsidiarity.
2. Make solidarity the fundamental principle to pay for basic education, basic personal services and pain management.
3. Cover individual risk profiles by basic insurance.
4. Support competitive health service and insurance markets.
5. Regulate quality in health services and insurance.
6. Make health care competence a prime political goal.
7. Provide protection for those who cannot care for themselves.
8. Provide a fair and competitive market for all stakeholders.

II Eight health care rules for *the lay person*:

1. Find truly educated and trustworthy health care experts.
2. Develop health care competence and responsibility.
3. Make extended use of predictive and preventive services.
4. Expect healing or relief from medical services; but be aware of limits and risks of medical interventions.
5. Request information and advice from medical experts and be a fair partner in communication and cooperation.
6. Define and implement your sense of qualities of life, from childhood to old age, in sickness and in health.
7. Prepare advance directives and name proxy decision makers for situations of compromised autonomy.
8. Act responsibly in the use of communal health care funds.

III Eight health care rules for *health professionals*:

1. Treat people as fellow humans, not just their symptoms.
2. Assist clients and patient to develop health risk competence.
3. Integrate the "clinical status" and the "value status" of your patient into differential ethics, diagnosis, and prognosis.
4. Be aware of the benefits, limits, and risks of medical intervention and share those with your patient.
5. Be a fair expert partner in communication and cooperation to those who seek your services, respect their values and wishes.
6. Provide excellent professional and personal services, continue to educate yourself and improve services.
7. Assist clients and patients in writing advance directives and be a fair partner to proxy decision makers.
8. Act responsibly in the use of communal health care funds.

IV Eight health care rules for *insurance professionals*:

1. Offer insurance for people as partners, not for profit alone.
2. Provide basic insurance for costs of health education, acute intervention, chronic illness and pain management.
3. Solidarity requires that individual differences in health risk profiles be included in basic insurance.
4. Offer competitive insurance for supplementary health care services based on client's preferences and risk profile.
5. Use health information as a competitive edge in providing services for health care.
6. Provide incentives or reduce premiums for partners with proven health care competence.
7. Encourage clients to have advance directives or designate surrogate decision makers; respect your client's choices.
8. Protect values and interests of all stakeholders in caring and paying for health.

glect is not caused by a lack of funds, but by a lack of recognizing the civil right to care for one's health and to be given the opportunities to do so in an educated and risk competent way. Information and education have to be recognized as basic human and civil rights.

Radical changes in existing systems of providing and insuring health care need to be supported by changing attitudes, first among those who structure systems, legislators and regulators, by those who provide and implement health care, disease management and financial services, and then by citizens capable of taking care of their health.

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